CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155135		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	CON	TE SURVEY MPLETED 9/2011	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	p. w.i.	STREET A	DDRESS, CITY, STATE, ZIP C LINIC DRIVE RD, IN47421	CODE	
(X4) ID PREFIX TAG F0000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Complaints IN00 IN00094264. The partially extended jeopardy. Complaint IN000 Federal/State defallegations were and F-490. Complaint IN000 Federal/State defallegations IN000 Federal/State IN0000 Federal/S	dis visit resulted in a d survey - immediate 093639-Substantiated. iciencies related to the cited at F-323, F-309, 094264- Substantiated. iciencies related to the cited at F-323, F-309, 28/11 date: 07/29/11 000060 : 155135 100266600 n, RN TC (07/28/11) RN	F0	000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

COSS11

Facility ID:

000060

TITLE

If continuation sheet

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/29/2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STRE 1510	DET ADDRESS, CITY, STATE, ZIP CODE O CLINIC DRIVE DFORD, IN47421	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(X5) COMPLETION DATE	
	REGULATORY OR LSC IDENTIFYING INFORMATION) Census Payor Type: Medicare: 16 Medicaid: 58 Other: 02 Total: 76 Sample: 03 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on August 2, 2011 by Bev Faulkner, RN				
F0309 SS=J	must provide the residents received care after the resident of the floor of the land 1/2 hours residents reviewed transfers received care after the residents reviewed the residents reviewed the residents reviewed transfers received care after the resident of the residents reviewed transfers received care after the resident of the resident of the resident residents reviewed transfers received care after the resident residents reviewed to the resident residents reviewed to the resident	st receive and the facility necessary care and services in the highest practicable and psychosocial well-being, in the comprehensive plan of care. We and record review, the ensure 1 of 3 sampled end for facility bus did timely assessment and ident had fallen forward chair and lay face down e van for approximately resulting in the resident all bruises and abrasions.	F0309	What corrective action was ta for those residents found to heen affected by the deficien practice? 1-The employee will drove the van with Resident was suspended on 7/12/11 pending investigation. The investigation was completed 7/13/11, and the bus driver involved in the incident was terminated. 2- A care plan will developed on 7/12/11 for Resident A addressing reside	nave the constraint of the con

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: COSS11 Facility ID:

000060

If continuation sheet

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE COMPI	
THIE TEAT	or condition	155135		LDING		07/29/2	
		100.00	B. WIN			0172072	
NAME OF I	PROVIDER OR SUPPLIEI	R		1	ADDRESS, CITY, STATE, ZIP CODE		
WEOT //		DELIABILITATION CENTED		1	LINIC DRIVE		
WESIVI	EW NURSING AND	REHABILITATION CENTER		BEDFO	RD, IN47421		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					refusal to wear seat belt. The		
	The Immediate 3	Jeopardy began on			approach was added that the		
	7/12/11 when Re	esident A was transported			facility would no longer tran resident due to her	sport	
		neelchair van without a			non-compliance. Alternative	<u> </u>	
	l -	n place. The driver of the			transportation will be arrang		
		on his brakes when			needed. 3-A system is now		
					place for van transportation	and	
	^	in front of the van			for the timely and proper		
	_	lent to be propelled out of			assessment when an incide		
		The Resident laid on the			occurs. How other Resident		
		at medical assistance for			having the potential to be at by the same deficient practi		
	approximately a	n hour and a half while			were identified? On 7/28/11		
	the facility drove	e from Bedford to			interviewable Resident in th		
	Indianapolis to a	assess her. The			facility was questioned abou	ıt seat	
		RN Corporate Consultant			belt compliance while riding	in the	
		Nursing were notified of			facility van. All residents		
		eopardy at 3:10 P.M. on			interviewed answered they		
					not try to remove the seat b while riding in the van. As s		
		nmediate jeopardy was			no other Residents were	oucii,	
		29/11 at 2:00 p.m., but			identified with the potential	of	
	_	remained at the lowered			being affected. What measu		
	_	ity of isolated, at no actual			were put into place or what		
		ntial for more than			systemic changes were ma		
	minimal harm th	nat is not immediate			ensure that the deficient pra		
	jeopardy.				does not recur? 1-On 7/12/3 plan was instituted to have	•	
					approved van drivers be	.116	
					instructed, before any other		
	Findings Include	à.			transports took place, on the		
					proper use of the seat belts		
	During interview	v of Resident A on			Completed on 7/13/11, instr		
	_				was provided to those drive		
		0 a.m., she indicated she			including placing those drive wheelchairs and having each		
		lent two weeks ago."			those drivers seat belting each		
		icated she had gone out			other in. They were also		
	1 * '	pointment in Indianapolis.			instructed on what to do wh	en a	
	Resident A indic	eated the driver had			resident refuses to use a se	at belt	
	secured her whe	el chair with straps, but			as well as what action to tal	ке	
		-					

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	AN OF CORRECTION IDENTIFICATION NUMBER: 155135		A. BUI	LDING	00	COMPLETED			
		155135	B. WIN			07/29/2011			
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE				
MESTA					LINIC DRIVE				
		REHABILITATION CENTER			BEDFORD, IN47421				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)			
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE COMPLETION DATE			
1710		o wear the seat belt due		mo	when a fall or accident occur				
		eavy and didn't like the			call 911) immediately, wheth	`			
	way the seat belt				not the Resident believes the	· I			
	*	cated upon arriving at			were injured. Assessment of	f			
		was told the appointment			learning was return demonstration. The instruction	n l			
		d. Resident A indicated			that was provided to all curre	• • • • • • • • • • • • • • • • • • •			
		tal with the driver and			drivers will also be provided	to			
	1	wear her seat belt.			any new drivers assigned the	e			
		ated they were on the			responsibility of transporting Residents. New driver instru	uction			
		ar swerved in front of			begins with a Job Specific	lotion			
		ver had to slam on his			Orientation which includes				
		ell forward "almost to the			wheelchair and seatbelt safe	•			
		Resident A indicated			well as calling 911 in case of emergency, such as if a fall of				
					incident occurs. How the				
	_	over to the side of the			corrective action will be mon	itored			
	1	ed to get her up off the			to ensure the deficient practi	ce			
		able to because she was			will not recur? 1-Return				
	1	lent A indicated she told			demonstration, which include how to properly apply seat be	• • • • • • • • • • • • • • • • • • •			
		s o.k. and the driver			and calling 911 if an incident				
		to report what had			occurs, will be completed thr				
		dent A indicated the bus			times weekly on anyone who				
		at he was instructed by			drives the bus for the next th days; weekly, for three montl				
	· ·	ve the resident on the			and monthly for at least three				
		cility arrived to help her.			months. 2-Results of these re	eturn			
	Resident A indica	•			demonstrations will be delive	ered			
		n the floor and she			to the Continuous Quality Improvement (CQI) Committ	ee			
		she had to lay on the floor			for ongoing Quality Assurance				
		arrived. The resident s on the floor 2 hours			review and appropriate follow				
		s on the floor 2 nours			as needed. Date changes				
					completed – 7/29/2011				
		ner up. Resident A							
		ministrator and the driver							
		nd sat her up and LPN #1							
		esident #A raised her shirt							
	at this time and s	even bright red ridges,							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155135	B. WIN			07/29/2	011
NAME OF	PROVIDER OR SUPPLIEI		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIED			1510 CI	LINIC DRIVE		
WESTVI	EW NURSING AND	REHABILITATION CENTER		BEDFO	RD, IN47421		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULE			(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	+	TAG	DLI ICILI CI I		DATE
	approximately 4 centimeters in length and 0.5 centimeters in width were observed						
		ent's abdomen. Resident A					
		ges were due to laying on					
	the bus floor.						
	Interview of I Di	N #1 on 07/28/11 at 11:15					
		t took about 1 hour to get					
		to Greenwood. LPN #1					
	1	ministrator had called a					
	1	ar the area of the facility					
		d that staff from the sister					
	1	ave immediately to assist					
		N #1 indicated she called					
		ld him the sister facility					
	1	y. LPN #1 indicated the					
	1	an incorrect location and					
	1	was on the west side and					
		vas on the east side. LPN					
		driver had followed					
	1	structions to get off of the					
	interstate and ha	d moved the bus with the					
	resident laying of	on the floor. LPN #1					
	indicated when s	she and the Administrator					
	found out that th	e facility bus was at a					
	different location	n they called the sister					
	facility and instr	ucted them not to come					
	· ·	nistrator and LPN#1 were					
	on their way and	l were closer to the					
	1	us than the sister facility.					
	1	d she assessed the					
	resident and she						
		N #1 indicated Resident					
		vn on the mat when they					

		X1) PROVIDER/SUPPLIER/CLIA	(X	(2) MUL	TIPLE CON	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A.	. BUILDI	NG	00		COMPI	
		155135	В.	. WING				07/29/2	011
NAME OF I	PROVIDER OR SUPPLIER			S	STREET AI	DDRESS, CITY, STATI	E, ZIP CODE		
TWINE OF F	RO VIDER OR BUILDER	•				INIC DRIVE			
WESTVII	EW NURSING AND	REHABILITATION CENTER	R	6	BEDFOF	RD, IN47421			
(X4) ID		TATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE				(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULI	- 1		EFIX	CROSS-REFERENCED	TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	1)	7	ΓAG	DEFIC	IENCY)		DATE
		the exact same width as							
	the aisle. LPN #1 indicated the resident denied any pain. LPN #1 indicated she and the Administrator slid a gait belt								
		nt and after 3 attempts							
		ve the resident to the back							
		e they could sit her up.							
	LPN #1 indicated	d upon assessment of the							
	resident, the resid	dent was found to have							
	red ridges across	her abdomen, red							
	blotches on her k	nees, and a bleeding							
	elbow. LPN #1 i	indicated Resident A was							
	able to tell her he	er name and where she							
	lived and Resider	nt A denied pain except a							
	sore ankle.								
	Interview of the	Administrator on							
	07/28/11 at 11:40	a.m., indicated it didn't							
	occur to him to c	all EMT's [Emergency							
	Medical Technic	ians] due to the resident							
		t hurt. The Administrator	.						
		called the sister facility							
		ey would go to assist the							
	_	Iministrator indicated he							
		an driver to confirm the							
		van driver told him he							
		an and had driven about 8							
		e Administrator indicated							
		he was closer to the van							
		cility so he called the							
		•							
	-	I told them not to come. or indicated the resident							
	didn't request EM	/I I `S.							
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID	: COS	SS11	Facility II	D: 000060	If continuation sl	neet Pa	ge 6 of 39

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155135		A. BUII	LDING	NSTRUCTION 00		DATE SURVEY COMPLETED 7/29/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	 DDRESS, CITY, STATE, ZIP COE LINIC DRIVE RD, IN47421		725/2511
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	Nursing] on 07/2 indicated when the facility to report thought was to can would arrive soothe Administrator resident and she facility was goinhelp the resident. Interview of the 07/28/11 at 2:30 A had requested [anti-anxiety medue to the resident sleeping. The Nindicated that on complained of path The Nurse Practicity opened and the dath of the Nurse Practicity palpated the resident didn't concern the Nurse Practicity	Nurse Practitioner on p.m., indicated Resident an increase in her Xanax edication] on 07/14/11 and having trouble curse Practitioner 07/19/11 the resident ain under her left breast. It tioner indicated the ident's abdomen had cressing was sticking. It tioner indicated she ident's abdomen and the					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
ANDILAN	or connection	155135		LDING	00	07/29/2	
		.00.00	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				LINIC DRIVE		
WESTVI	EW NURSING AND	REHABILITATION CENTER		1	RD, IN47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE		DATE
	1	A Resident Progress Note, dated 07/12/11 at 6:45 a.m., indicated, "Resident [A]					
	· ·						
	LOA to Dr[nan facility provided						
	l racinty provided	transportation.					
	A Resident Progr	ress Note, dated 07/12/11					
	1	licated Resident A's vital					
	· ·	at that time and were as					
	1 ~	ature - 97.3, heart rate -					
	1 ^	20, and blood pressure -					
	130/60.						
	A Resident Progr	ress Note, dated 07/12/11					
	at 1:00 p.m., indi	cated, "Arrived at van @					
	11:00 a.m. reside	ent lying face down in the					
	floor/aisle of the	van. Res [Resident A]					
	denied any pain a	at this time. Res A&O					
	[alert and oriente	ed] to place, name, and					
	staff present. As	sessed face/neck,					
	· · · · · · · · · · · · · · · · · · ·	ooth arms for mobility.					
	. –	during the assessment.					
	_	ced under the resident by					
	_	Pirector] and LPN #1 &					
		er [Resident A] back					
		es slightly up while LPN					
		vards the back of the bus					
		attempts and successful.					
		and (driver of van) lifted					
	res with gait belt	_					
	1 -	a sitting position. Head					
		t done per this nurse. All					
		Right elbow bleeding					
	_	injury. Pressure applied.					
	Bruising on both	knees, sheering on her					

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CO	NSTRUCTION		(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	155135	P	A. BUILD	ING	00		07/29/2	
		100100	E	B. WING				0112312	011
NAME OF F	PROVIDER OR SUPPLIER	3				DDRESS, CITY, ST	ATE, ZIP CODE		
WESTVII	FW NURSING AND	REHABILITATION CENTER				INIC DRIVE RD, IN47421			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		DI	ID REFIX		PLAN OF CORRECTION IVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENC	CED TO THE APPROPRIATE (FICIENCY)	ΓE	DATE
		areas of discoloration] on							
	' ' '	nall abrasion on left							
		resident in wheelchair							
		oulder] strap and lap belt							
	_	el belts. ED drove van							
		k to facility. This nurse							
		d DNS reported to							
	[resident's physic	•							
		2:30 p.m. regarding this							
	incident."	F							
	A Resident Progr	ress Note, dated 07/12/11							
	at 1:15 p.m., indi	icated, "Resident returned							
	from MD [Medic	cal Doctor]							
	appointment"	-							
	An X-ray, dated	07/12/11, indicated							
	Resident A had "	'soft tissue swelling" of							
	her right ankle.								
	A Resident Progr	ress Note, dated 07/13/11							
	at 1:46 p.m., indi	icated, "Resident up with							
	assistance this sh	nift. Resident received							
	PRN [as needed]	pain medication once							
	this shift for gene	eral all over discomfort							
	with effect. Resi	ident was screen							
	[screened] by the	erapy this shift and							
	therapy is going	to pick Resident up on							
	caseload. Reside	ent is propelling self in							
	wheel chair to me	neals. Bruising continues							
	to inferior left br	reast, purple in color.							
	Slight discolorati	ion also noted to left							
	knee. Abrasions	s to abdomen have no							
	signs or sympton	ms of infection. vital [sic]							
FORM CMS-2	2567(02-99) Previous Versio	ons Obsolete Event ID:	CO	SS11	Facility I	D: 000060	If continuation sl	neet Pa	ge 9 of 39

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155135		A. BUI	LDING	00	07/29/2	
		100100	B. WIN			0112312	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
WESTVII	FW NURSING AND	REHABILITATION CENTER		1	LINIC DRIVE RD, IN47421		
					10, 1111 121		(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	signs within normal limits, neuro checks WNL [within normal limits]. Call light in						
	reach."	1 0					
	A Resident Progr	ress Note, dated 07/13/11					
	at 3:30 p.m., indi						
		Team] met to review					
	1	7/12/2011 at 9:20 a.m.					
	Resident fell out	of chair while being					
	transported to M	D via facility van.					
	Resident has seve	eral bruises and					
	abrasions. Resid	ent stated when the van					
	stopped she fell of	out of her chair on to the					
	van floor. When	this nurse asked if she					
	was belted in, res	sident stated, 'I wont [sic]					
	wear a seat belt a	and if they put it on I [sic]					
	just unhook it and	d hold it after they start					
	to drive.' Neuro	checks were started at the					
	scene with nurse	doing a head to toe					
	assessment. MD	/NP [Medical					
	Doctor/Nurse Pra	actitioner] and family					
	notified. X ray to	o right foot and ankle					
		dence of fracture. PT					
	1	y] OT [Occupational					
	Therapy] to scree	en."					
		ress Note, dated 07/13/11					
	at 4:48 a.m., indi						
	continues on F/U						
	Resident requeste	-					
	-	2:30 a.m. d/t [due to]					
		Bruising noted to body					
	1	es. Resing [Resting]					
	quietly abed at th	nis time."					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S COMPLI	
		155135	B. WIN			07/29/20	011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET A	ADDRESS, CITY, STATE, ZIP CODE LINIC DRIVE RD, IN47421		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	at 5:15 p.m., indi Resident A's phy	ress Note, dated 07/13/11 (cated, "[Name of sician] here to see resec'd [Received] w.o.					
	at 10:14 p.m., inc	ress Note, dated 07/13/11 dicated, "Resident cont					
		u [follow-up] for fall.					
		some complaint of pain					
	•	laint of genral [sic] pain					
	stated it did help.	edication given. Resident"					
	An X-ray, dated Resident A had n	07/20/11, indicated o rib fractures.					
	Director of Nursi	form completed by the ing, dated 7/12/11, 1/11 at 9:20 AM [sic]					
		meeting E.D. [Executive					
		d call from van driver					
	_). ED came to this nurse					
	`	nd told this nurse he and					
		ng to assist van driver.					
		opped and resident fell					
		floor. After morning					
		AM [sic] this nurse					
	called ED who w	vas in route to van stating					
	ambulance shoul	d be called in case of					
	injury. ED had ca	alled sister facility in					
		om was close and DNS					
	-	sing Services] with her					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAIN	OF CORRECTION	155135	- 1	LDING	00	07/29/2011	
		100100	B. WIN		DDDEGG CITY GTATE ZID CODE	0772072011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE LINIC DRIVE		
WESTVII	EW NURSING AND	REHABILITATION CENTER		1	RD, IN47421		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		N
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE	
	staff was going to						
		ce needed to be called.					
	_	had talked with van					
		nt whom stated she was					
		LPN (name) stated she did					
		sment and initiated neuro					
		arrived at van location,					
		drove van back to facility.					
	7/13/2011 This n	urse did head to toe					
	assessment and n	neasured each bruise and					
	abrasion 7/12/	/2011 xray of R [right]					
	foot and ankle. N	To fracture or dislocation.					
	7/20/2011 Xray r	ribs no fracture, NP					
	[Nurse Practition	er] saw and examined					
	resident on 7/15/	2011 and 7/19/2011."					
	Documentation t	itled "Timeline for					
		cident was provided by					
		r on 07/29/11 at 11:10					
		entation was dated July					
		ocumentation indicated					
		ocumentation mulcated					
	the following:						
	"9:20 a.m Rec	eived call from bus					
	driver that [name	of resident] had fallen					
	_	nair and was on the floor					
		ols [Indianapolis]. Spoke					
	_	name of resident] on that					
	-	ned that [name of					
		feeling any pain and in					
	=	right. Told the driver					
		coming to help and he					
	told us their loca	-					
	1314 45 41011 1004						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135		A. BUIL	DING	nstruction 00	(X3) DATE S COMPL 07/29/2	ETED	
	PROVIDER OR SUPPLIEF	IL	B. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE LINIC DRIVE RD, IN47421		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re	(X5) COMPLETION DATE
IAU	9:30 a.m ED [Nurse set out to the site since it shad been careles fall and thus, the the bus or the result of the bus	Executive Director] and help. ED needed to get to ounded like the driver is allowing the resident to edriver should not drive sident any further. I drive was going to be and a half, so in route, we is a lower to find the location for the location wing out the resident and arrive to the location. I drive was going to be and a half, so in route, we is a location wing out the resident and arrive to the location. I drive was going to be and a half, so in route, we is a location wing out the resident and arrive to the location. I drive was going to be and a half, so in route and further side in the location was and further from the accility the location was and further from the accility the location until and the location until led the location of hursing and her that we were now were. They were in route and [sic] them for their		IAU			DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155135		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S COMPL 07/29/2	ETED	
		199139	B. WIN			0772972	011
NAME OF	PROVIDER OR SUPPLIER	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
WESTVI	EW NURSING AND	REHABILITATION CENTER			_INIC DRIVE RD, IN47421		
					110, 11111121		(1/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
	effort.						
	11:00 a.m We	arrived at the location.					
	Nurse performed	d initial assessment. We					
	spoke with [nam	ne of resident] who said					
	she was alright.	We positioned [name of					
	resident] better	to get her into a sitting					
	position. Nurse	continued the assessment.					
	We stood [name	of resident] and placed					
	her into her wheelchair. Nurse completed						
	the assessment.						
	1:30 p.m Arriv	ved back to [name of					
	facility]. ED had	d driven the van back					
	after confirming	that driver had not					
	properly seat-be	lted the resident allowing					
	her to fall. Resid	dent was wheeled into the					
	center and then s	she wheeled herself into					
	the main dining	room and began setting					
	the room up for	the afternoon Bingo					
	game."						
		titled "RE: Incident with					
		Resident on 7/12/11" was					
	1 *	Administrator on					
		p.m. The documentation					
	· ·	3/11. The documentation					
	listed intervention						
	_	correct the immediate					
	1 " "	acility immediately					
		rivers that any resident					
	1 -	d were to be properly seat					
		rs were instructed on what					
	to do when a res	ident refused to wear a					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135	(X2) MULTIPLE CO A. BUILDING B. WING	00		E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET A 1510 Cl	ADDRESS, CITY, STATE, ZIP C LINIC DRIVE PRD, IN47421	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	addressing her read the driver in was terminated. fall/accident white transport, and a reaccompanied by immediate assess for immediate assend the DON and immediately be of the facility inserved to take when a reseat belt and on a accident occurs of without nursing. The non-compliately lowered scope are isolated, no actual more than minimized in the policies and prace effective.	le en route during a resident is not nurse to provide sment, 911 will be called sessment for the resident d Administrator will				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155135	B. WING		07/29/2011
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	1510 CL	DDRESS, CITY, STATE, ZIP CODE LINIC DRIVE RD, IN47421	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
F0323 SS=J	The facility must e environment rema hazards as is poss receives adequate devices to prevent Based on intervier record review, that I of 3 sampled refacility bus transformed that transformed the transformed to the facility bus transformed to the facility	nsure that the resident ins as free of accident sible; and each resident expervision and assistance accidents. ew, observation, and e facility failed to ensure esidents reviewed for fers was properly secured	F0323	What corrective action was ta for those residents found to heen affected by the deficien practice? 1-The employee who drove the van with Resident was suspended on 7/12/11 pending investigation. The investigation was completed 7/13/11, and the bus driver involved in the incident was terminated. 2- A care plan who developed on 7/12/11 for Resident A addressing resider refusal to wear seat belt. The approach was added that the facility would no longer transpresident due to her	aken 07/30/2011 nave tho A on as ent's e

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: COSS11 Facility ID:

000060

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155135 07/29/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1510 CLINIC DRIVE WESTVIEW NURSING AND REHABILITATION CENTER BEDFORD, IN47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE seat belt being in place. The driver of the non-compliance. Alternative transportation will be arranged as van had to slam on his brakes when needed. 3-A system is now in someone pulled in front of the van place for van transportation and causing the resident to be propelled out for the timely and proper assessment when an incident of her wheelchair. The Resident lay on the occurs. How other Residents van floor without medical assistance for having the potential to be affected approximately an hour and a half while by the same deficient practice the facility drove from Bedford to were identified? On 7/28/11, each Indianapolis to assess her. The interviewable Resident in the facility was questioned about seat Administrator, RN Corporate Consultant belt compliance while riding in the and Director of Nursing were notified of facility van. All residents the Immediate Jeopardy at 3:10 P.M. on interviewed answered they would 7/28/11. The immediate jeopardy was not try to remove the seat belt while riding in the van. As such, removed on 07/29/11 at 2:00 p.m., but no other Residents were noncompliance remained at the lowered identified with the potential of scope and severity of isolated, no actual being affected. What measures harm, with potential for more than were put into place or what systemic changes were made to minimal harm, that is not immediate ensure that the deficient practice jeopardy. does not recur? 1-On 7/12/11, a plan was instituted to have the approved van drivers be instructed, before any other Findings Include: transports took place, on the proper use of the seat belts. During interview of Resident A on Completed on 7/13/11, instruction 07/28/11 at 10:30 a.m., she indicated she was provided to those drivers including placing those drivers in had a "bad accident two weeks ago." wheelchairs and having each of Resident #A indicated she had gone out those drivers seat belting each for a doctor's appointment in Indianapolis. other in. They were also Resident A indicated the driver had instructed on what to do when a resident refuses to use a seat belt secured her wheel chair with straps, but as well as what action to take she had refused to wear the seat belt due when a fall or accident occurs (to to she was too heavy and didn't like the call 911) immediately, whether or way the seat belt "squeezed" her. not the Resident believes they were injured. Assessment of Resident #A indicated upon arriving at

STATEMEN	NT OF DEFICIENCIES	DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3)		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155135	B. WIN			07/29/2	011
			_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	t .		1510 CI	LINIC DRIVE		
	EW NURSING AND	REHABILITATION CENTER			PRD, IN47421		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
IAG	•	LSC IDENTIFYING INFORMATION)	+	IAG	learning was return		DATE
	_	was told the appointment			demonstration. The instruction	n	
		ed. Resident A indicated			that was provided to all curre		
	_	ital with the driver and			drivers will also be provided		
		wear her seat belt.			any new drivers assigned the	•	
		ated they were on the			responsibility of transporting Residents. New driver instru	ection	
		ear swerved in front of			begins with a Job Specific		
		ver had to slam on his			Orientation which includes		
		ell forward "almost to the			wheelchair and seatbelt safe	•	
		'Resident A indicated the			well as calling 911 in case of		
	_	er to the side of the road			emergency, such as if a fall of incident occurs. How the	ונ	
	1	get her up off the floor			corrective action will be mon	itored	
	but was unable to because she was too				to ensure the deficient practi	ce	
	heavy. Resident A indicated she told the				will not recur? 1-Return		
	driver she was o	k. and the driver called			demonstration, which include		
	the facility to rep	oort what had happened.			how to properly apply seat be and calling 911 if an incident		
	Resident A indic	ated the bus driver told					
	her that he was is	nstructed by the facility to			times weekly on anyone who		
	leave the residen	t on the floor until the			drives the bus for the next th	-	
	facility arrived to	help her. Resident A			days; weekly, for three month and monthly for at least three		
	indicated it was	very uncomfortable on			months. 2-Results of these re		
	the floor and she	couldn't believe she had			demonstrations will be delive	red	
	to lay on the floo	or until the facility			to the Continuous Quality		
	arrived. The res	ident indicated she was			Improvement (CQI) Committ for ongoing Quality Assurance		
	on the floor 2 ho	urs before the			review and appropriate follow		
	Administrator ar	nd LPN #1 arrived to			as needed. Date changes	·	
	assist her up. Re	esident A indicated the			completed – 7/29/2011		
	Administrator ar	nd the driver turned her					
	over and sat her	up and LPN #1 assessed					
		A raised her shirt at this					
	time and seven b	oright red ridges,					
		centimeters in length and					
		n width were observed					
	across the reside	nt's abdomen. Resident A					
	indicated the ridge	ges were due to laying on					
	approximately 4 0.5 centimeters i across the reside	centimeters in length and n width were observed nt's abdomen. Resident A					
	mulcated the flag	ges were due to laying on					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155135	A. BUI	LDING	00	07/29/2	
		100100	B. WIN			0112312	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WESTVII	FW NI IRSING AND	REHABILITATION CENTER		1	LINIC DRIVE PRD, IN47421		
				ļ	110, 1147 421		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
	the bus floor Re	esident A indicated she					
		6:45 a.m. and arrived at					
	1	dianapolis at about 8:45					
	a.m.						
	Interview of LPN	V #1 on 07/28/11 at 11:15					
		took about 1 hour to get					
		to Greenwood. LPN #1					
	1	s told by the driver and					
	Resident #A that	the wheelchair had been					
	fastened in all 4 p	points, brakes were on,					
	and tie down stra	ps were on front and					
	back, but the seat	t belt was not fastened.					
	LPN #1 indicated	d the Administrator had					
	called a sister fac	cility near the area of the					
	facility bus and v	vere told that staff from					
	the sister facility	would leave immediately					
	to assist the resid	ent. LPN #1 indicated					
	she called the dri	ver and told him the					
	sister facility was	s on their way. LPN #1					
	indicated the driv	ver had given an incorrect					
		sister facility was on the					
		facility bus was on the					
		1 indicated the driver had					
		e east side with the					
		oor of the bus. LPN #1					
		ver had followed Resident					
	#A's instructions						
		‡1 indicated when she					
		rator found out that the					
	1 -	at a different location they					
		acility and instructed					
		e due to the Administrator					
	and LPN#1 were	on their way and were					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155135	A. BUI	LDING	00	COMPL 07/29/2	
		100100	B. WIN			0112312	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
WESTVII	EW NI IRSING AND	REHABILITATION CENTER		1	LINIC DRIVE PRD, IN47421		
					110, 1117721		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
		tion of the bus than the	+				21112
		PN #1 indicated she					
	· ·	dent and she was moving					
	all extremities. I						
		face down on the mat					
		d and was the exact same					
	1	e. LPN #1 indicated the					
		ny pain. LPN #1					
		I the Administrator slid a					
		e resident and after 3					
	~						
	attempts were able to move the resident to the back of the aisle where they could sit						
	her up. LPN #1 indicated upon						
	_	e resident, the resident					
		re red ridges across her					
		otches on her knees, and a					
		LPN #1 indicated					
		ble to tell her her name					
		ved and Resident A					
	denied pain exce						
	defined pain exce	pt a sore anxie.					
	Interview of the	Administrator on					
		a.m., indicated it didn't					
		all EMT's due to the					
		he wasn't hurt. The					
		dicated he had called the					
		I they said they would go					
	l -	lent. The Administrator					
		called the van driver to					
		tion and the van driver					
		noved the van and had					
	driven about 8 m						
		dicated he then realized					
		the van than the sister					
	110 1145 010501 10	, all thall the bibter					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLI	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155135	A. BUI	LDING	00	07/29/20	
		155135	B. WIN			07729720	711
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
WESTVI		REHABILITATION CENTER		1	LINIC DRIVE		
				L	RD, IN47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
IAG	!	ed the sister facility and	+	IAG			DAIL
	1	come. The Administrator					
		ted to make sure the					
		it belted in" when she					
		cility so he made a					
		during the transport back					
	1 1 1						
	to the facility. The factor	ened the resident's seat					
		realize that as soon as he he unfastened the seat					
	belt and had it placed across her lap as if secured. The Administrator indicated the						
		quest EMT's [Emergency					
		ians]. The Administrator					
		not aware the resident					
	refused to wear s	eat belts.					
	Interview of the	DON on 07/28/11 at 2:15					
		hen the van driver called					
	1 * '	ort what happened, her					
	1 -	to call 911 due to EMT's					
		ner. The DON indicated					
		r said he had talked to the					
		was o.k. and a sister					
		g to the van location to					
		The DON indicated she					
	_	e resident did not wear					
		e accident occurred, no					
	one had reported						
	Interview of the	Nurse Practitioner on					
		p.m., indicated Resident					
		an increase in her Xanax					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE S COMPL	
		155135	A. BUII B. WIN			07/29/2	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	р. үүн	STREET A	ADDRESS, CITY, STATE, ZIP CODE LINIC DRIVE RD, IN47421		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	edication] on 07/14/11					
	due to the resider	•					
	sleeping. The Nu	19/11, the resident					
		ain under her left breast.					
		tioner indicated the					
	ridges on the resi	ident's abdomen had					
	opened and the d	ressing was sticking.					
		tioner indicated she					
	palpated the resident's abdomen and the						
	resident didn't complain of pain.						
		ent A's clinical record on 5 p.m., indicated the					
		tiagnoses which included, ited to, CVA [stroke] and					
	assessment, dated resident was mod impaired and was interview for me	G (Minimum Data Set) d 07/01/11, indicated the derately cognitively s able to complete an intal status, the resident ce of two staff for lking.					
	at 6:45 a.m., indi LOA to Dr[nan facility provided	ress Note, dated 07/12/11 cated, "Resident [A] ne of doctor] in Indy via transportation."					
	A Kesidelit F10gi	.css 1101c, dated 07/12/11					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155135	A. BUI	LDING	00	07/29/20	
		100100	B. WIN			01123120	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WESTVI	FW NURSING AND	REHABILITATION CENTER		1	LINIC DRIVE PRD, IN47421		
		TATEMENT OF DEFICIENCIES		ID ID			(7/5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	DATE
	at 11:00 a.m., inc	licated Resident A's vital	ĺ				
	signs were taken	at that time and were as					
	follows: Temper	ature - 97.3, heart rate -					
	80, respirations -	20, and blood pressure -					
	130/60.						
	1	07/12/11, indicated					
	Resident A had "	soft tissue swelling" of					
	her right ankle.						
		ress Note, dated 07/12/11					
	at 1:00 p.m., indicated, "Arrived at van @						
		ent lying face down in the					
		van. Res [Resident A]					
	1	at this time. Res A&O					
	l -	d] to place, name, and					
	staff present. As	·					
	· ·	ooth arms for mobility.					
		during the assessment.					
	1 ^	ced under the resident by					
	_	virector] and LPN #1 & er [Resident A] back					
		es slightly up while LPN					
		vards the back of the bus					
	from the aisle.	varus the back of the bus					
		accessful. ED, LPN # 1,					
		a) lifted res with gait belt					
	1	eposition res in a sitting					
	1	o toe assessment done per					
	1 ~	ital signs WNL. Right					
		rom a previous injury.					
	I -	Bruising on both knees,					
		pelly. Purpura [areas of					
	discoloration] on	left forearm. Small					

NAME OF PROVIDER OR SUPPLIER WESTVIEW NURSING AND REHABILITATION CENTER ID PROVIDER OR SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) abrasion on left elbow. Secured resident in wheelchair with should [shoulder] strap and lap belt and 4 point wheel belts. ED drove van and resident back to facility. This nurse notified DNS and DNS reported to [resident's physician], NP [Nurse Practitioner] at 12:30 p.m. regarding this incident." A Resident Progress Note, dated 07/12/11 at 1:15 p.m., indicated, "Resident returned from MD [Medical Doctor] appointment" A Resident Progress Note, dated 07/13/11 at 1:46 p.m., indicated, "Resident received PRN [as needed] pain medication once this shift. Resident received PRN [as needed] pain medication once this shift for general all over discomfort with effect. Resident was screen [screened] by therapy this shift and therapy is going to pick Resident up on caseload. Resident is propelling self in wheel chair to meals. Bruising continues to inferior left breast, purple in color. Slight discoloration also noted to left	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135		(X2) MULTIP A. BUILDING B. WING		OO	(X3) DATE S COMPL 07/29/2	ETED	
PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION) abrasion on left elbow. Secured resident in wheelchair with should [shoulder] strap and lap belt and 4 point wheel belts. ED drove van and resident back to facility. This nurse notified DNS and DNS reported to [resident's physician], NP [Nurse Practitioner] at 12:30 p.m. regarding this incident." A Resident Progress Note, dated 07/12/11 at 1:15 p.m., indicated, "Resident returned from MD [Medical Doctor] appointment" A Resident Progress Note, dated 07/13/11 at 1:46 p.m., indicated, "Resident up with assistance this shift. Resident received PRN [as needed] pain medication once this shift for general all over discomfort with effect. Resident was screen [screened] by therapy this shift and therapy is going to pick Resident up on caseload. Resident is propelling self in wheel chair to meals. Bruising continues to inferior left breast, purple in color.				15	10 CL	INIC DRIVE		
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knee. Abrasions to abdomen have no signs or symptoms of infection. vital [sic] signs within normal limits, neuro checks WNL [within normal limits]. Call light in reach." A Resident Progress Note, dated 07/13/11 at 3:30 p.m., indicated, "IDT		in wheelchair wind and lap belt and drove van and retent This nurse notification reported to [reside [Nurse Practition regarding this in the A Resident Progat 1:15 p.m., and from MD [Mediappointment" A Resident Progat 1:46 p.m., and assistance this slight for gene with effect. Resent [screened] by the therapy is going caseload. Reside wheel chair to me to inferior left by Slight discolorate knee. Abrasions signs or symptom signs within nor wind the side of the signs of the signs within nor reach."	th should [shoulder] strap 4 point wheel belts. ED sident back to facility. ed DNS and DNS dent's physician], NP ner] at 12:30 p.m. cident." ress Note, dated 07/12/11 icated, "Resident returned cal Doctor] ress Note, dated 07/13/11 icated, "Resident up with nift. Resident received pain medication once eral all over discomfort ident was screen erapy this shift and to pick Resident up on ent is propelling self in reals. Bruising continues reast, purple in color. ion also noted to left to abdomen have no ms of infection. vital [sic] mal limits, neuro checks remal limits]. Call light in ress Note, dated 07/13/11					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	li i	ATE SURVEY MPLETED	
		155135	A. BUII B. WIN	LDING IG			9/2011
NAME OF I	DROLUDER OR CURRULER		B. WIN		DDRESS, CITY, STATE, ZIP CO	ODE	
	PROVIDER OR SUPPLIER				INIC DRIVE		
		REHABILITATION CENTER		BEDFO	RD, IN47421		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)		DATE
	[Interdisciplinary	Team] met to review					
	residents fall on	7/12/2011 at 9:20 a.m.					
	Resident fell out	of chair while being					
	_	D via facility van.					
	Resident has seve						
		lent stated when the van					
	1 11	out of her chair on to the					
		this nurse asked if she					
	· ·	sident stated, 'I wont [sic]					
		and if they put it on I [sic]					
	ľ	d hold it after they start					
	to drive.' Neuro checks were started at the scene with nurse doing a head to toe						
	assessment. MD	-					
		actitioner] and family o right foot and ankle					
	1	dence of fracture. PT/OT					
		y will no longer transport					
	due to seat belt n	-					
		on compilance.					
	A Resident Progr	ress Note, dated 07/13/11					
	at 4:48 a.m., indi	cated, "Resident					
	continues on F/U	[follow-up] fall.					
	Resident request	•					
	-	2:30 a.m. d/t [due to]					
	_	Bruising noted to body					
	1	ces. Resing [Resting]					
	quietly abed at th	nis time."					
	A Resident Progr	ress Note, dated 07/13/11					
		dicated, "Resident cont					
	_	u [follow-up] for fall.					
	-	some complaint of pain					
		laint of genral [sic] pain					
		- 0 [] [1

		X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	ļ	A. BUILD	ING	00		COMPL	
		155135	J	B. WING				07/29/2	011
NAME OF I	PROVIDER OR SUPPLIER	₹				DDRESS, CITY, STA	ATE, ZIP CODE		
VA/EOTV/II		DELIADULITATION OFNITED				LINIC DRIVE			
WESTVII	EW NURSING AND	REHABILITATION CENTER			BEDFO	RD, IN47421			
(X4) ID		STATEMENT OF DEFICIENCIES			ID		PLAN OF CORRECTION		(X5)
PREFIX	*	NCY MUST BE PERCEDED BY FULL			REFIX	CROSS-REFERENC	VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	\rightarrow		TAG	DEF	ricienci)		DATE
		edication given. Resident							
	stated it did help.)"							
	•	07/20/11, indicated							
	Resident A had n								
		Job Specific Orientation							
		by the bus driver and							
	dated 6/26/10, in	ndicated "Seatbelt							
	(Required for all	l passengers/driver)"							
	An investigation	form completed by the							
	Director of Nursi	ing, dated 7/12/11,							
	indicated "7/12	2/11 at 9:20 AM [sic]							
	during morning r	meeting E.D. [Executive							
	Director] receive	ed call from van driver							
	-	e). ED came to this nurse							
	*	and told this nurse he and							
		s going to assist van							
	` '	d van stopped and resident							
		onto floor. After morning							
		AM [sic] this nurse							
	•	vas in route to van stating							
		ld be called in case of							
		alled sister facility in							
		om was close and DNS							
	•	sing Services] with her							
	=	to assess resident and							
		nce needed to be called.							
		had talked with van							
	-	ent whom stated she was							
		LPN (name) stated she did							
		ssment and initiated neuro							
		e arrived at van location,							
	on resident. ED o	drove van back to facility.							
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	CO	SS11	Facility I	D: 000060	If continuation s	heet Pa	ge 26 of 39

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		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILD	ING	00		COMPL	
		155135		B. WING				07/29/2	U11
NAME OF F	PROVIDER OR SUPPLIER					DDRESS, CITY, STA	ATE, ZIP CODE		
			_			INIC DRIVE			
WESTVII	EW NURSING AND	REHABILITATION CENTER	₹		BEDFO	RD, IN47421			
(X4) ID		STATEMENT OF DEFICIENCIES		-	ID		PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION			REFIX	CROSS-REFERENCE	/E ACTION SHOULD BE ED TO THE APPROPRIAT TICIENCY)	E	COMPLETION
TAG)		TAG	DEI	remer)		DATE
		nurse did head to toe							
		measured each bruise and							
		urse asked resident how							
		esident stated (Bus driver							
	, 	an and I fell in the floor. I							
		ner head and she stated							
		r redness noted on							
		his nurse ask if resident							
	_	t belts and resident stated							
		a seat belt and if they put							
	-	shook it and hold it after							
		e. I unhooked my seatbelt							
	,	rator's name) was driving							
		didn't even know it.' This							
		dent if she knew why the							
		riven while she was still							
		ident stated "(bus driver							
		ng get up (Resident A							
	•	d at him to just drive and							
	-	he also told this nurse she							
	,	s driver name) fired. This							
	-	to resident the possible							
	_	d have had and the danger							
	_	ut a seatbelt on. Resident							
		re I am not wearing a							
		y to screen. Facility will							
	-	ident d/t [due to] non							
	-	seat belt. Facility will							
		t with (name) or (name)							
		1 xray of R [right] foot							
	and ankle. No fra	acture or dislocation.							
	7/20/2011 Xray r	ribs no fracture, NP							
	[nurse practitions	er] saw and examined							
	resident on 7/15/	/2011 and 7/19/2011."							
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID	CO	SS11	Facility I	D: 000060	If continuation sh	neet Pa	ge 27 of 39

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155135		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	COM	TE SURVEY SPLETED 0/2011	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STRE 1510	EET ADDRESS, CITY, STATE, Z O CLINIC DRIVE DFORD, IN47421	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	with the Administracility would not Resident A because the belt during to indicated he had and told them not refused to wear a done an inservice. On 7/28/11 at 3: with the Administrator of the bus driver conceres Resident A. He continued in the bus driver has because he violated they are not to transitionally assengers/driver. Transportationall passengers/driver.	15 P.M., in an interview strator he indicated there tatement taken from the rning the incident with did indicate during an ne bus driver he had nt A had refused to wear e Administrator indicated d been terminated ted facility policy because ansport any resident elt. Littled "Activity river Job Specific ram" was provided by the n 07/28/11 at 11:00 a.m. fron was dated, 02/28/07. Iton indicated, nSeatbelt (Required for				

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STATEMENT OF DEFICIENCIES (X1) P		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155135	B. WIN			07/29/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	· ·		1510 CI	LINIC DRIVE		
	EW NURSING AND	REHABILITATION CENTER		BEDFO	PRD, IN47421		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, the state of the	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFECT.)		DATE
	_	nave narrow aisles which					
	were approxima	tely 20 inches wide.					
	Two other reside	ent charts were reviewed					
		residents and indicated					
	1	id wear seat belts.					
	uicse residents d	nu wear sear belts.					
	Documentation 1	titled "RE: Incident with					
		Resident on 7/12/11" was					
		Administrator on					
	^ ·	p.m. The documentation					
		3/11. The documentation					
	listed intervention						
		correct the immediate					
	1 1	acility immediately					
		rivers that any resident					
		d were to be properly seat					
		rs were instructed on what					
		ident refused to wear a					
		ent A was care planned					
		efusal to wear a seat belt;					
		red in the incident was					
		he event of a fall/accident					
		uring a transport, and a					
		ecompanied by nurse to					
		ate assessment, 911 will					
	l ~	nediate assessment for					
	the resident and						
		ill immediately be					
	contacted.	in ininiculatory oc					
	comacieu.						
	The immediate i	eopardy that began on					
		moved and the deficient					
		ed on 07/29/11 when the					
	practice correcte	d on 07/27/11 WHCH the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155135		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 0/2011	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	1510 C	ADDRESS, CITY, STATE, ZIP ELINIC DRIVE DRD, IN47421	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	07/29/11 at 1:30 driver of the bus suspended and to investigation; all inserviced on no unless they were Resident A was a be transported by non-compliance Alternative trans arranged as need indicated, "No rewithout a seatbel safety belt." The remained at the I severity level of with potential for harm that is not in because of the no monitoring to en practices put in peffective. This federal tag is					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155135			(x2) MULTIPLE CONSTRUCTION (x3) DATE SURVEY A. BUILDING B. WING (x2) MULTIPLE CONSTRUCTION (x3) DATE SURVEY COMPLETED 07/29/2011					
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 CLINIC DRIVE BEDFORD, IN47421					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (XS) COMPLETION DATE			
F0490 SS=J	that enables it to use and efficiently to a practicable physical well-being of each. Based on record interview, the face effective system.	administered in a manner use its resources effectively taken or maintain the highest al, mental, and psychosocial resident. The review, observation, and callity failed to insure an awas in place to identify fused to wear seat belts	F0490	What corrective action was t for those residents found to l been affected by the deficier practice? 1-The employee w drove the van with Resident was suspended on 7/12/11	have have			

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Event ID:

COSS11 Facility ID:

000060

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155135	B. WIN	G		07/29/2011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TWINE OF I	NO VIDEN ON SOLVEIEN			1	LINIC DRIVE	
WESTVI	EW NURSING AND	REHABILITATION CENTER		BEDFO	RD, IN47421	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	when transported	l in facility vehicles and			pending investigation. The	
	failed to have an	effective system in place			investigation was completed 7/13/11, and the bus driver	on
	to guide staff on	procedures to follow			involved in the incident was	
	when an incident	occurred during van/bus			terminated. 2- A care plan w	_{ras}
		This actually affected 1 of			developed on 7/12/11 for	
	•	wed for seat belt used			Resident A addressing reside	ent's
		tion. (Resident A)			refusal to wear seat belt. Th	
	during transporta	tion. (Resident A)			approach was added that the	
					facility would no longer trans resident due to her	port
					non-compliance. Alternative	
		eopardy began on			transportation will be arrange	
		sident A was transported			needed. 3-A system is now in	
	in the facility wh	eelchair van without a			place for van transportation a	
	seat belt being in	place. The driver of the			for the timely and proper	
	van had to slam o	on his brakes when			assessment when an incider	·
	someone pulled i	n front of the van			occurs. How other Residents	l l
	-	ent to be propelled out			having the potential to be aff by the same deficient praction	
	_	r. The Resident lay on the			were identified? On 7/28/11,	
		t medical assistance for			interviewable Resident in the	
		hour and a half while			facility was questioned abou	t seat
					belt compliance while riding	in the
	the facility drove				facility van. All residents	
	Indianapolis to as				interviewed answered they w	
		N Corporate Consultant			not try to remove the seat be while riding in the van. As so	
		Jursing were notified of			no other Residents were	JOI 1,
	the Immediate Je	opardy at 3:10 P.M. on			identified with the potential o	f
	7/28/11. The im	mediate jeopardy was			being affected. What measur	
	removed on 07/2	9/11 at 2:00 p.m., but			were put into place or what	_
		emained at a lowered			systemic changes were mad	
	_	ty level of isolated, no			ensure that the deficient practices not recur? 1-On 7/12/1	
	*	potential for more than			plan was instituted to have the	l l
		nat is not immediate			approved van drivers be	.
	•	iat is not inimediate			instructed, before any other	
	jeopardy.				transports took place, on the	
					proper use of the seat belts.	
					Completed on 7/13/11, instru	
	Findings Include	:			was provided to those driver	S

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION . DULL DIVIS . 00			(X3) DATE SURVEY COMPLETED	
ANDILAN	of connection	155135	A. BUI			07/29/2011
		100100	B. WIN			0112912011
NAME OF I	PROVIDER OR SUPPLIER	2		1	ADDRESS, CITY, STATE, ZIP CODE	
\\/_CT\ '''		DELIADII ITATIONI OENTEE		1	LINIC DRIVE	
WESTVII	EW NURSING AND	REHABILITATION CENTER		REDLO	RD, IN47421	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
					including placing those driv wheelchairs and having each	
	_	of Resident A on			those drivers seat belting e	
	07/28/11 at 10:30 a.m., she indicated two				other in. They were also	
	weeks ago she le	eft the facility at 6:45			instructed on what to do wh	nen a
	a.m., for a docto	r's appointment at a			resident refuses to use a se	
	hospital in India	napolis. Resident A			as well as what action to tal	
	_	owed the facility bus			when a fall or accident occu	
		her wheelchair with			call 911) immediately, whet not the Resident believes the	
		ed to be seat belted in her			were injured. Assessment	
	_	Resident indicated upon			learning was return	
		spital at about 8:45 a.m.,			demonstration. The instruct	
		appointment had been			that was provided to all cur	
		ent A indicated on the			drivers will also be provided any new drivers assigned the	
					responsibility of transporting	
	I	cut in front of the facility			Residents. New driver insti	
		er had to slam on his			begins with a Job Specific	
	1	used the resident to be			Orientation which includes	
		ont of the bus. The			wheelchair and seatbelt saf	•
		ed she was lying face			well as calling 911 in case of emergency, such as if a fall	I
	down in the aisle	e of the bus and couldn't			incident occurs.How the	
	get up. The Res	ident indicated the bus			corrective action will be mo	nitored
	driver immediate	ely pulled over and			to ensure the deficient prac	tice
	attempted to get	the resident up but was			will not recur? 1-Return	
	unable to. The b	ous driver called the			demonstration, which include how to properly apply seat	I
	facility and was	instructed to leave the			and calling 911 if an incider	
	1 ~	loor until help arrived.			occurs, will be completed th	
		or had talked to the bus			times weekly on anyone wh	10
		one and was told by the			drives the bus for the next t	
	1	sident was not hurt. The			days; weekly, for three mor and monthly for at least thre	
		ontacted a sister facility in			months. 2-Results of these	I
		made arrangements for			demonstrations will be deliv	
	_	_			to the Continuous Quality	
	the sister facility to go to the location of the resident and provide assistance as				Improvement (CQI) Commi	
					for ongoing Quality Assurar	
	needed. The Administrator left the				review and appropriate follo as needed. Date changes	νν-uμ
	l racinty at Bedfo	rd to go to the location of			as needed. Date ondinges	
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID: (COSS11	Facility 1	ID: 000060 If continuation	sheet Page 33 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155135	B. WIN			07/29/2	U11
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	•	
				1	LINIC DRIVE		
WESTVII	EW NURSING AND	REHABILITATION CENTER		BEDLO	RD, IN47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	completed – 7/29/2011		DATE
		apolis to drive the			Completed – 1/29/2011		
	Resident back to	the facility.					
	Internitore of the	DON on 07/28/11 at 2:15					
	1 *	when the van driver called port what happened, her					
	1 .	to call 911 due to EMT's					
	_	dical Technicians] would					
		help the resident. The					
		he suggested calling an					
		se the resident was hurt.					
		ted she was told by the					
		at he had talked to the					
		was O.K. and the sister					
	assistance.	neir way to provide					
	assistance.						
	During the trip to	Indianapolis, the					
		lled the bus driver to					
		tion and found the bus					
		the bus farther and was					
		first location. The					
	· -	alized he was closer to					
		the sister facility so he					
		facility and told them					
	not to come.	racinty and told mon					
	200 00 001110.						
	The Resident wa	s assessed by LPN #1					
	The Resident was assessed by LPN #1 upon arrival to the bus and was found to						
	have right elbow bleeding from a previous						
	_	on both knees, and					
	• •	pelly. Purpura [areas of					
	· -	left forearm and a small					
	abrasion on left e						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155135		(X2) MULTIP A. BUILDING B. WING		00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	15 ⁻	IO CLII	DRESS, CITY, STATE, ZIP CODE NIC DRIVE D, IN47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		ent A's clinical record on o.m., indicated the					
	Resident A had diagnoses which included, but were not limited to, CVA [stroke] and obesity.						
	A quarterly MDS assessment, date resident was mo impaired and wa interview for me required assistant transfers and wa						
	A Resident Prog at 6:45 a.m., ind LOA to Dr[nat facility provided						
	Orientation Prog Administrator of The documentat The documentat	river Job Specific gram" was provided by the n 07/28/11 at 11:00 a.m. ion was dated, 02/28/07. ion indicated, nSeatbelt (Required for					
	at 4:30 p.m., to h	was observed on 07/28/11 nave narrow aisles, which tely 20 inches wide.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE (COMPL 07/29/2	ETED	
		155135	B. WIN			07/29/2	011
NAME OF I	PROVIDER OR SUPPLIER	8		1	DDRESS, CITY, STATE, ZIP CODE		
WESTVI	EW NURSING AND	REHABILITATION CENTER		1	LINIC DRIVE RD, IN47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	for transport of r	ent charts were reviewed esidents and indicated id wear seat belts.					
	De aum antation t	itled "Timeline for					
		itled "Timeline for					
		ident was provided by the on 07/29/11 at 11:10 a.m.					
		ion was dated July 12,					
		mentation indicated the					
	following:	incliation malcated the					
	ionowing.						
	driver that [name from her wheeld of the van in ind with driver and [call and determinesident] was no her words was all	ceived call from bus the of resident] had fallen thair and was on the floor the pls [Indianapolis]. Spoke thame of resident] on that the detail that [name of the feeling any pain and in the driver the coming to help and he tion.					
	Nurse set out to the site since it s had been careles fall and thus, the	Executive Director] and help. ED needed to get to ounded like the driver s allowing the resident to driver should not drive sident any further.					
	about an hour an contacted our AS	drive was going to be d a half, so in route, we GC building [sister t of Indpls. I asked if					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 07/29/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE		
WESTVI	EW NURSING AND	REHABILITATION CENTER		BEDFO	RD, IN47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	of our bus, check	by going to the location king out the resident and arrive to the location.					
	and told him that center. The other to his location to to confirm his lothat he had drive 'has less traffic.' now closer to us [sister facility naroute to help. It any place and to our arrival. 10:30 a.m I ca	ke with our bus driver t we had called another or center would be coming assist. Asked the driver cation. He informed us n to another location that His new location was and further from the me] team that was in old the driver to not drive stay at that location until					
	sister facility] DNS [Director of Nursing Services] and told her that we were now closer than they were. They were in route to assist us. I thank [sic] them for their effort.						
	Nurse performed spoke with [nam she was alright. resident] better position. Nurse We stood [name	arrived at the location. I initial assessment. We e of resident] who said We positioned [name of to get her into a sitting continued the assessment. of resident] and placed elchair. Nurse completed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED			
		155135	A. BUII			07/29/2			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE				
NAME OF P	PROVIDER OR SUPPLIER				LINIC DRIVE				
WESTVIEW NURSING AND REHABILITATION CENTER				BEDFORD, IN47421					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	TAG	DEFICIENCY)		DATE		
	O 7/20/11 + 2.15 P.M :								
	On 7/28/11 at 3:15 P.M., in an interview								
	with the Administrator, he indicated there was no written statement taken from the								
	bus driver concerning the incident with								
	Resident A. He did indicate during an								
	interview with the bus driver he had								
	indicated Resident A had refused to wear								
	her seat belt.								
	Interview of the A	Administrator on							
		p.m., indicated the							
		as not aware of the							
	facility having a policy regarding transport of residents.								
	transport of resid	Citto.							
	The immediate jeopardy that began on								
	07/12/11 was removed on 07/29/11 when								
	the facility implemented the plan to								
	immediately call 911 in the event of a resident who is not accompanied by a								
		ccident while en route							
	during transport	and inserviced all drivers							
	as to what steps t	o take if a resident							
	refuses to wear a	seat belt. The							
	non-compliance	remained at a lowered							
	scope and severit	y of isolated, no actual							
	_	ial for no more than							
	_	at is not immediate							
	jeopardy because	of the need to continue							
	to monitor and en	nsure the policies and							
	practices put in p	lace were followed and							
were effective.									

l	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135	(X2) MULTIPLE CC A. BUILDING B. WING	00	li i	ESURVEY PLETED 2011		
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 CLINIC DRIVE BEDFORD, IN47421					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	(X5) COMPLETION DATE			
	facility to ensure and care were prafter the resident on to the floor of Refer to F-323 refacility to ensure with a seat belt of facility vehicles, falling from the wedged in the air.	egarding the failure of the Resident A was secured luring transportation in resulting in the resident wheelchair and being						